## MICHIGAN DEPARTMENT OF COMMUNITY HEALTH

## BUREAU OF HEALTH SYSTEMS INFORMAL DEFICIENCY RESOLUTION REQUEST – LEVEL 2

Send this form (typed/printed) with documentation to:

MDCH, BHS, Operations, Enforcement Unit, IDR Requests, P.O. Box 30664, Lansing, MI 48909.

The PoC should be submitted to the Licensing Officer that signed the Statement of Deficiencies (CMS-2567L).

## This IDR is to be reviewed by:

☐ Bureau of Health System	ms Staff OR	☐ MPRO (Facility a	grees to pay fee for service).
Facility:		Survey Exit	Date:
1. Tag No(s):			
2. Citation fact(s)/statemer	nt(s) requested for review:		
	ou believe refutes the above fact( ered; for example, 1 of 20, 2 of 20		
4. Explain if the above evid	dence was not available at time of	of survey:	
		In .	In "
Facility Contact Person:		Date:	Phone #:
	REVIEWER RES	PONSE – LEVEL 2	
Deficiency is:	☐ Supported in full	☐ Amended	☐ Deleted
Reason:			
Reviewer Signature:		Code/s: 1 2	3 4 5 6 7 8 9 10 11
By:		Title:	Date:

BHS-108 (12/03)

Authority: P.A. 368 of 1978 as amended

The Michigan Department of Community Health will not discriminate against any individual or group because of race, sex, religion, age, national origin, color, marital status, disability, or political beliefs. If you need assistance with reading, writing, hearing, etc. under the Americans with Disabilities Act, you may make your needs known to this Agency.